ANNUAL STATEWIDE 1915(i) HOME & COMMUNITY BASED SERVICES (HCBS) STATE PLAN ADULT DAY HEALTH CARE (ADHC) & HOME BASE HABILITATION SERVICES (HBHS) REVIEW FINAL REPORT 2022

HCBS Serving Individuals enrolled in ADHC and HBHS Quality Assurance (QA) review to ensure the service continues to meet essential federal statutory assurances and effectively meet the recipient's needs.

State of Nevada

Division of Health Care Financing and Policy

Managed Care & Quality Assurance

June 2023

State Plan Year 3

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Background/Introduction

The State Plan Amendment (SPA) renewal of the Adult Day Health Care (ADHC) and Home Base Habilitation Services (HBHS) are contingent on the Centers for Medicare and Medicaid Services (CMS) determining that the state has effectively assured the health and welfare of state plan recipients during the period the SPA has been in effect.

The state is required under 1915(i)(1)(H) to ensure that the provision of state plan Home Based Habilitation Services (HCBS) meets federal and state guidelines for quality assurance. In addition, under 42 Code of Federal Regulation (CFR) §441.745: "States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the state plan HCBS benefit and the number of individuals to be served.". CMS must assess each state plan HCBS benefit to determine that the state requirements are met. The assessment also serves to inform CMS in its review of the state's request for renewal of these services.

CMS conducts quality reviews, requiring states to demonstrate their use of performance measures to collect HCBS data and address how they conduct discovery, remediation, and quality improvement activities.

A state must demonstrate oversight through performance measures included in its §1915(i) state plan HCBS benefit. When a performance measure falls below the threshold of eighty-six percent (86%), further analysis is required to determine the cause and the Quality Management Activities implemented unless the state provides acceptable justification clarifying why system improvement is not necessary.

Performance Measures

CMS evaluates the state's oversight and monitoring systems according to outcome-based evidence in the form of performance measures. Well-crafted performance measures indicate whether the state is meeting the federal requirements for the approved SPA benefit. The performance measures drive the state's Quality Improvement Strategy (QIS) and form the basis of the evidence provided to CMS.

The state's performance measures are assessed by CMS based on the following seven criteria:

1. The performance measure is stated as a metric (e.g., number or percent), and specifies a numerator and denominator (i.e., is the performance measure measurable?).
2. The performance measure has face validity (i.e., Does the performance measure truly measure the requirement?).
3. The performance measure data is based on the correct unit of analysis (e.g., participants, providers, claims, etc.). The unit of analysis should be linked to the requirement measured.
4. The performance measure data is based on a representative sample of the population. The performance measure data should have at least a ninety-five percent (95%) confidence level with a +/- five percent (5%) margin of error. If the state chooses to stratify a sample to allow for a representative sample of subgroups, the state must "re-weight" the data in order to make estimates for the population as a whole.
5. The performance measure must provide data specific to the state plan benefit undergoing evaluation.
6. The performance measure data demonstrates the degree of compliance for each period of data collection.
7. The performance measure determines the health of the system, (e.g., does the performance measure evaluate the anticipated outcome of the requirement as opposed to measuring a beginning step in the process?).

Aims & Objectives

The annual review monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems, and individual corrective actions. The results can be aggregated and analyzed to measure the overall system performance in meeting the service assurances.

Methodology

CMS quality requirements are founded on an evidence-based approach. CMS requests evidence from the state that it meets the assurances and applies a continuous quality improvement approach to the assurances. Effective October 2019, the Division of Health Care Financing and Policy (DHCFP) Quality Assurance (QA) Unit implemented a monthly process to allow the state to achieve higher administrative efficiency, a natural process of current and continuous quality improvement, and prevent duplication. The DHCFP QA unit uses a representative sample producing a probability of a ninety-five percent (95%) confidence level with a +/- five percent (5%) confidence interval (95/5) to determine the statewide total of recipient files to be reviewed by the DHCFP Long Term Support Services (LTSS) 1915i team and the DHCFP QA staff. This (95/5) sample is used to determine the required number of financials reviews needed. A second sample producing a probability of a ninety-five percent (95%) confidence level with a +/- ten percent (10%) confidence interval (95/10) is used to determine the required number of recipient cases that the DHCFP QA unit staff will evaluate throughout the review year. The total number is distributed evenly over the year. All recipients' cases selected will be evaluated using the twelve (12)

months immediately preceding the month the review is conducted.

The annual review for the HCBS state plans ADHC & HBHS for the State of Nevada was conducted from March 1, 2022 through February 28, 2023. The 95/5 determined a sample size of two hundred ninety-four (294) reviews required. The 95/10 determined a sample size of ninety (90) reviews assigned to the DHCFP QA unit and the remaining two hundred four (204) reviews to be completed by the DHCFP LTSS 1915i team. The DHCFP QA unit reviewed a random sample of ninety (90) case files for ADHC and HBHS combined with thirty-five (35) supervisor reviews completed from the DHCFP LTSS 1915i team. The DHCFP QA unit reviewed two hundred ten (210) recipient's financial claims, wherein seven (7) had no billed claims in the month selected for the 2022-2023 service plan year.

On October 24, 2022, CMS approved an amendment to the SPA allowing a ten percent (10%) sample size. The ten percent (10%) determined a sample size of one hundred twenty-five (125) reviews required. The DHCFP QA unit kept the previously determined 95/10 sample size of ninety (90) reviews since this was already calculated and put in place prior to the approval of the ten percent (10%). It was decided the remaining thirty-five (35) reviews were to be completed by the DHCFP LTSS 1915i team. This reduction from two hundred ten (210) to thirty-five (35) reviews to be completed by the DHCFP LTSS 1915i newly hired supervisor would be more obtainable while learning the roles and responsibilities. The total amount of financials was reduced from two hundred ninety-four (294) to two hundred ten (210) due to the change to ten percent (10%). During the first round of financials, one hundred forty-seven (147) financials were completed covering half of the year. With the mid-year reduction in sample size, DHCFP QA elected to review fifty percent (50%) of the newly approved ten percent (10%) sampling which resulted in sixty-three (63) financials completed in the second round.

The following areas were evaluated during this year's annual review:

Case File Review:

1. State Plan Eligibility
2. State Plan Service Received
3. Service Plan (SP)
4. Prior Authorization (PA)
5. DHCFP Plan of Care (POC)
6. Statement of Choice (SOC)

Financial Review:

1. Recipient Eligibility
2. PA
3. Claim
4. Daily Record
5. Payment
6. Provider

At the beginning of the plan year, both the case file and financial review forms were updated to ensure all review elements were supported in policy, having removed any obsoleted questions no longer supported with policies within the one year look back.

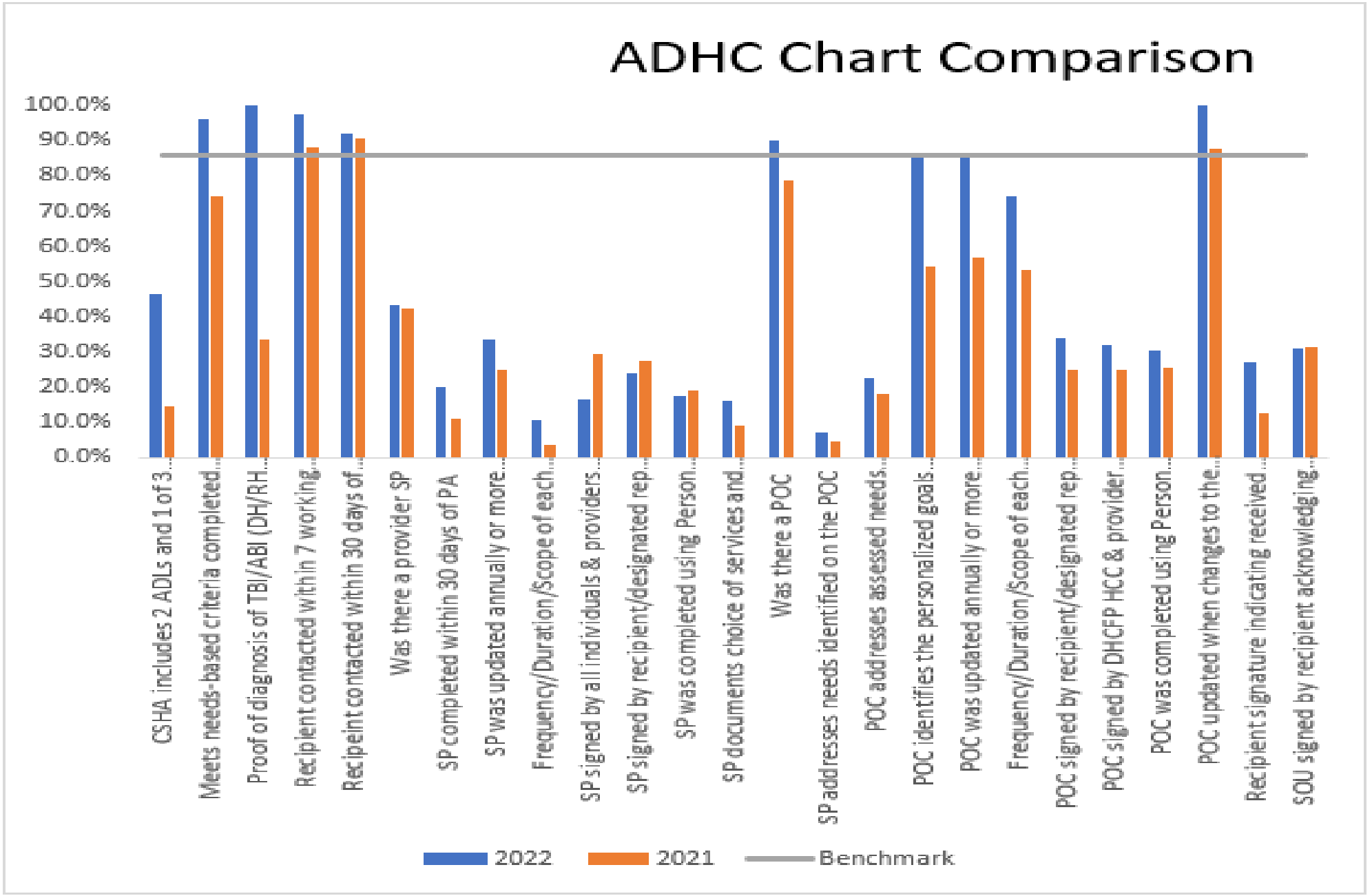
Listed below are the specific 1915(i) ADHC and HBHS, Medicaid Services Manual (MSM), State Plan, CFRs, Final Rule CMS, Nevada Administrative Code and Policy and Procedure used in the implementation of this annual review:

- MSM Chapter 100 Medicaid Program (Effective 08/28/2019, Updated 08/27/2019)
- MSM Chapter 1800 HCBS State Plan Option Adult Day Healthcare and Habilitation (Effective 01/08/2015, Updated 03/01/2020) (Effective 02/01/2023 Updated 01/31/2023)
- MSM Chapter 3300 Program Integrity (Effective 05/01/2019, Updated 04/30/2019)
- State Plan: 1915(i) HCBS State Plan Services (Effective 10/01/2019, Amended 03/01/2020) (Effective 07/01/2022, Amended 10/24/2022)
- CFR- 441-540/CFR- 441.720/CFR-441.725
- Final Rule CMS 2249-F & CMS 2296-F
- Nevada Administrative Code (NAC) 449.4087/NAC 449.4088
- Policy and Procedure (P&P) Adult Day Health Care and Habilitation Policy and Procedure Memo 2020-1

The following results identify the areas and percentages of compliance with Quality Improvement Strategy (QIS) and requirements outlined in the above policies.

2022 Statewide Case File Review Results ADHC/DHRH

Eligibility	CSHA includes 2 ADLs & 1 of 3 specific risk factors	46.4%
	CSHA completed annually or more frequently as needed	96.0%
	Proof of diagnosis of TBI/ABI (DH/RH only)	100.0%
	Recipient contacted within 7 working days of referral date	97.6%
	Recipient contacted within 30 days of PA ending to initiate a face-to-face re-evaluation	92.0%
Provider Service Plan (SP)	Was there a provider SP	43.2%
	SP completed within 30 days of PA	20.0%
	SP was updated annually or more frequently as needed	33.6%
	Frequency/Duration/Scope of each service was identified on the SP	10.4%
	SP signed by all individuals & providers responsible	16.5%
	SP signed by recipient/designated rep with documentation	24.1%
	SP was completed using Person Centered Planning	17.6%
	SP documents choice of services and providers	16.0%
DHCFP Plan of Care (POC)	Was there a POC	90.4%
	SP addresses needs identified on the POC	7.2%
	POC addresses assessed needs identified on CSHA	22.4%
	POC identifies the personalized goals of the POC	85.6%
	POC was updated annually or more frequently as needed	86.4%
	Frequency/Duration/Scope/Amount of each service was identified	74.4%
	POC signed by recipient/designated rep with documentation (New referrals only, within 60 days of SOU)	33.8%
	POC signed by DHCFP HCC & provider signed within 60 days of POC date	32.0%
	POC was completed using Person Centered Planning	30.4%
	POC updated when changes to the recipient occur during authorization period	100.0%
	Recipient signature indicating received information & contact list for reporting critical incidences at initial and annual assessments	26.9%
	SOU signed by recipient acknowledging they had the right to choose the services and providers at initial assessment	30.7%


ADHC Chart Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
CSHA includes 2 ADLs and 1 of 3...
Meets needs-based criteria completed...
Proof of diagnosis of TBI/ABI (DH/RH...
Recipient contacted within 7 working...
Recipeint contacted within 30 days of...
Was there a provider SP
SP completed within 30 days of PA
SP was updated annually or more...
Frequency/Duration/Scope of each...
SP signed by all individuals & providers...
SP signed by recipient/designated rep...
SP was completed using Person...
SP documents choice of services and...
Was there a POC
SP addresses needs identified on the POC
POC addresses assessed needs...
POC identifies the personalized goals...
POC was updated annually or more...
Frequency/Duration/Scope of each...
POC signed by recipient/designated rep...
POC signed by DHCFP HCC & provider...
POC was completed using Person...
POC updated when changes to the...
Recipient signature indicating received...
SOU signed by recipient acknowledging...
2022
2021
Benchmark

Quality Improvement Strategy

(Percentages calculated by adding "Yes" and "N/A" answers and dividing by total number of answers)

* QIS noted below are elements reviewed and reported to by DHCFP QA. All other elements not addressed below is reported directly from DHCFP LTSS 1915i team.

Requirement 1: Plan of Care (POC)
a) address assessed needs of 1915(i) participants; b) are updated annually; c) document choice of services and providers.

Sub-requirement 1-a Service plans address assessed needs of 1915(i) participants.

ADHC & HBHS Combined 14.8%
Questions 15-16

- **Question 15: SP Addresses needs identified on the POC** (7.2%): In comparison to the 2021 plan year, this question shows a two-point eight percent (2.8%) increase in compliance. These deficiencies were due to either the service plan not being uploaded into OnBase or the service plan did not address all needs reported on the plan of care.

  Recommendation: Set a calendar reminder to follow up with provider two weeks after the POC has been mailed out to ensure the service plans are returned to the Health Care Coordinator (HCC) timely. Provide training to all providers to ensure the needs noted in the POC are present in the service plan being created. The creation of a standard service plan for all providers to use could also reduce confusion or missed needed information. DHCFP LTSS 1915i team has begun having quarterly meetings with the providers to discuss documentation and compliance with review/audit requests. We should see an increase in this element in the next review period. DHCFP QA recommended the removal of the service plan requirement as it appears to be a duplication of efforts. The POC is given to the provider, who signs and returns it acknowledging the needs to be addressed. By removing the requirement to then have the provider create an additional service plan that mimics their signed acknowledgement would greatly reduce errors in this element.

- **Question 16: POC addresses assessed needs identified on CSHA** (22.4%): In comparison to the 2021 plan year, this question shows a four-point six percent (4.6%) increase in compliance. In most cases, the deficiency was due to services not matching due to the POC having additional services not reported on the CSHA.

  Recommendation: DHCFP LTSS 1915i team created a desk manual for HCCs to use to complete their assessments. The desk manual has been updated several times throughout the year to ensure best practices are being followed. On February 15th, 2023, DHCFP QA held a training with HCCs addressing question 16 on what documentation is looked at and what is needed to meet this element. System limitations were discussed as well as where review information would be located and what would be reported to ensure the CHSA and POC would match.

Sub-requirement 1-b Service plans are updated annually.

ADHC & HBHS Combined 60.0%
Questions 8, 18

- **Question 8: SP was updated annually or more frequently as needed** (33.6%): In comparison to the 2021 plan year, this question shows an eight-point nine percent (8.9%) increase in compliance. In most cases, the deficiency was due to the service plan not being uploaded into OnBase.

  Recommendation: Set a calendar reminder to follow up with provider two weeks after POC has been mailed out to ensure the service plans are returned to the Health Care Coordinator (HCC) timely. DHCFP QA recommended the removal of the service plan requirement as it appears to be a duplication of efforts. The POC is given to the provider, who signs and returns it acknowledging the needs to be addressed. By removing the requirement to then have the provider create an additional service plan that mimics their signed acknowledgement would greatly reduce errors in this element.

- **Question 18: POC was updated annually or more frequently as needed** (86.4%): In comparison to the 2021 plan year, this question shows a twenty-nine-point seven percent (29.7%) increase in compliance. This element is in compliance however, when cited the deficiency were due to the POC either not being created or imported into SAMS or not being uploaded into OnBase.

  Recommendation: DHCFP LTSS 1915i team created a desk manual for HCCs to use to complete their assessments. The desk manual has been updated several times throughout the year to ensure best practices are being followed. The manual would reinforce timeframes are being adhered to as well as the POCs being uploaded to SAMs or OnBase once completed.

Sub-requirement 1-c Service plans document choice of services and providers.

ADHC & HBHS Combined 16.0%
Question 13

- **Question 13: SP documents choice of services and providers** (16.0%): In comparison to the 2021 plan year, this question shows a seven-point one percent (7.1%) increase in compliance. In most cases, the deficiency was due to the SP not being uploaded into OnBase.

  Recommendation: Set a calendar reminder to follow up with provider two weeks after POC has been mailed out to ensure the service plans are returned to the HCC timely. DHCFP QA recommended the removal of the service plan requirement as it appears to be a duplication of efforts. The POC is given to the provider, who signs and returns it acknowledging the needs to be addressed. By removing the requirement to then have the provider create an additional service plan that mimics their signed acknowledgement would greatly reduce errors in this element. DHCFP LTSS 1915i team has updated the POC to address new settings requirements. With this addition, choice has been added to the HCCs POC and would address this element.

Requirement 2: Eligibility Requirements

a) an evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is a reasonable indication that 1915(i) services may be needed in the future; b) the process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and c) the 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the state plan for 1915(i) HCBS

Sub-requirement 2-b The process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately

ADHC & HBHS Combined Questions 1 46.4%

- **Question 1: CSHA includes 2 ADLs and 1 of 3 specific risk factors** (46.4%): In comparison to the 2021 plan year, this question shows a twenty-nine-point seven percent (29.7%) increase in compliance. In most cases, the deficiency was due to the CSHA not clearly documenting the specific risk factor used for approval.

  Recommendation: DHCFP LTSS 1915i team created a desk manual for HCCs to use to complete the CSHA. The desk manual has been updated several times throughout the year to ensure best practices are being followed.

Sub-requirement 2-c The 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.

ADHC & HBHS Combined Questions 2 96.0%

- **Question 2: CHSA completed annually or more frequently as needed** (96.0%): In comparison to the 2021 plan year, this question shows a twenty-one-point six percent (21.6%) increase in compliance. This element is in compliance however, when cited the deficiency was due to the CSHAs not being completed in the same month or earlier.

- ***Recommendation:*** DHCFP LTSS 1915i team created a desk manual for HCCs to use to complete the CSHA which reinforces timeframes are being adhered to. The desk manual has been updated several times throughout the year to ensure best practices are being followed.

Requirement 6: Financial Accountability

The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

ADHC & HBHS Combined Questions 14	0.4%

- **Question 14: Payment to provider correct based on claim submitted** (0.4%): In comparison to the 2021 plan year, this question shows a three-point one percent (3.1%) decrease in compliance. In most cases, the deficiency was due to either not receiving verifications from the provider or DHCFP LTSS 1915i team not clearly documenting recipient eligibility to receive services due to unclear or missing risk factor.

  Recommendation: Ensure CSHA's clearly document the risk factor used for approval. DHCFP LTSS 1915i team has begun having quarterly meetings with the providers to discuss documentation and compliance with review/audit requests. We should see an increase in this element in the next review period.

2022 Statewide Financial Review Results Combined for ADHC & HBHS

State Plan Eligibility	Recipient is eligible on the date of service	25.2%
	No conflicting services during the month	94.8%
Service Authorization	Service is prior authorized	98.7%
Claim	Procedure code correct	99.6%
	Service units billed fall within the PA units allowed	67.8%
	Billed at correct rate	91.7%
Daily Record	Services provided match the DHCFP POC	3.0%
	Frequency of services match the DHCFP POC	56.1%
	Service units/days provided match units/days billed and for which payment was received	75.2%
	Daily attendance & nursing logs signed by recipient	33.5%
	Daily attendance & nursing/daily log signed by provider staff	39.6%
	Documented recipient is unable to sign	95.7%
	Provider submitted signature page	99.1%
Payment	Payment to provider is correct based on claim submitted	0.4%
	Services paid according to the Medicaid allowable rate	99.6%
	Overpayment to provider	99.6%*
	Referral made to Surveillance and Utilization Review (SUR) Unit	99.6%*
Provider	Provider eligible for payment at time of service	100.0%

**Denotes measures for which a higher percentage rate suggests lower compliance.*

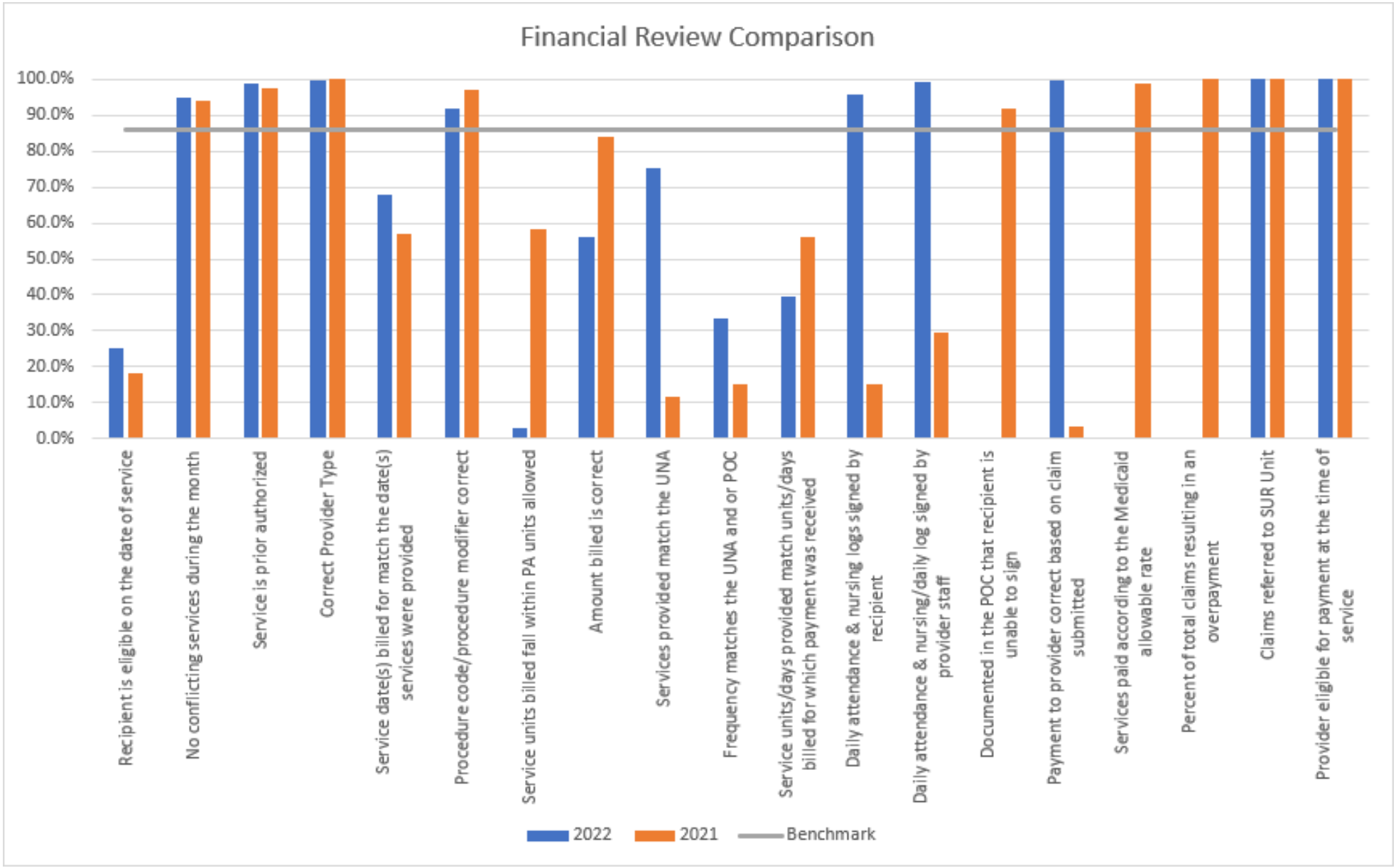
2022 Financial Review

The annual combined financial review confirms one (1) measure are at 100% compliance: .

- Provider eligible for payment at time of service

In addition, there are seven (7) additional measures that are above the 86% compliance benchmark:

- No conflicting services during the month- 94.8%
- Service is prior authorized- 98.7%
- Procedure code - 99.6%
- Billed at correct rate- 91.7%
- Documented that recipient is unable to sign- 95.7%
- Provider submitted signature page - 99.1%
- Services paid according to the Medicaid allowable rate- 99.6%


Financial Review Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Recipient is eligible on the date of service
No conflicting services during the month
Service is prior authorized
Correct Provider Type
Service date(s) billed for match the date(s) services were provided
Procedure code/procedure modifier correct
Service units billed fall within PA units allowed
Amount billed is correct
Services provided match the UNA
Frequency matches the UNA and or POC
Service units/days provided match units/days billed for which payment was received
Daily attendance & nursing logs signed by recipient
Daily attendance & nursing/daily log signed by provider staff
Documented in the POC that recipient is unable to sign
Payment to provider correct based on claim submitted
Services paid according to the Medicaid allowable rate
Percent of total claims resulting in an overpayment
Claims referred to SUR Unit
Provider eligible for payment at the time of service
2022
2021
Benchmark

Providers

DHCFP LTSS 1915i team continues to conduct Provider Reviews going forward and entering information into ALiS (Online Provider Review System) database to be tracked and flagged for deficiencies. Depending on the deficiencies, DHCFP LTSS 1915i team will send referrals to the appropriate state agency for review and create a corrective action plan, if necessary.

Additional Recommendations

- Ensure CSHA clearly calls out the Risk Factor.
- Ensure all needed documents are uploaded into OnBase.
- Be specific when creating the POC and specifying the frequency for services. Avoid using "yearly" when the frequency is daily, weekly, or monthly.
- Use a calendar alert system, within SAMS, if possible, for time sensitive documents. This will allow the HCC to recognize which items need action on any given date.
- Consider removing the provider service plans as is a duplication of efforts with DHCFP LTSS 1915i team's POC.
- If provider service plans will continue to be required, possible training or standard service plans could be provided at the DHCFP LTSS 1915i team's quarterly provider meetings, as to the importance of documentation requirements and timely submissions.
- Continue to have quarterly meetings with providers to ensure understanding and importance of adherence to new policies and procedures.

Observations

- DHCFP QA holds a monthly QI meeting (DHCFP LTSS 1915i team and DHCFP QA unit) to go over the results for the case files reviews that were conducted.
- In an effort to mitigate errors from last year's 2021 report, DHCFP LTSS 1915i team submitted and received approval from CMS for the amended SPA effective 03/01/2020.
- DHCFP LTSS 1915i team created a Desk Manual on 02/15/2023 to ensure all referrals and reassessments were completed correctly.
- DHCFP LTSS 1915i team held a public workshop on 11/03/2022 and public hearing on 01/31/2023 wherein the updating of MSM 1800 was approved effective 02/01/2023.
- DHCFP LTSS 1915i team held trainings on needs-based criteria, specific risk factors, CSHA assessment and created templates to use when writing the CSHA narrative.
- DHCFP LTSS 1915i team held monthly meetings with all HCCs to focus on issues identified in the DHCFP QA priority grid.
- DHCFP LTSS 1915i team held individual meetings with all HCCs on recently completed new referrals, ongoing cases, discussed deficiencies and made remediation plans when necessary.

Best Practices

Best practices are methods or techniques that represent the most efficient or prudent course of action. The following practices were observed contributing to the quality of health and welfare of state plan recipients:

- On 07/27/2022, DHCFP QA provided DHCFP LTSS 1915i team a streamlined checklist to help ensure all required documentation would be included within each recipient's case file.
- On 05/17/2022, DHCFP LTSS 1915i team made a guide that would help the HCCs complete the CSHA in an attempt to provide clarity and consistency when conducting assessments. This guide was updated on 02/15/2023.
- On 02/15/2023, QA held a training with all HCCs to discuss the comparing of the CSHA to the POC.

Case File Review Requirements

Assurance	NAC/State Plan/CMS	State Plan /CMS	MSM Requirement	MSM Chapter
ADHC & HBHS Eligibility Criteria				
Meets needs-based criteria on CSHA with ADLs.	HCBS-In order to qualify for services, the individual meets at least two of the following: The inability to perform two or more ADLs; 2. the need for significant assistance to perform ADLs; 3. risk of harm; the need for supervision; functional deficits secondary to cognitive and /or behavioral impairments. HCBS-Objective evaluation of the inability to perform or need for significant assistance to perform two or more ADLs (as defined in §7702B(c)(2)(B) of the Internal Revenue Code of 1986) ***Definition of ADLs from §7702B(c)(2)(B) of the Internal Revenue Code of 1986: (B) Activities of daily living for purposes of subparagraph (A), each of the following is an activity of daily living: (i) Eating. (ii) Toileting. (iii) Transferring. (iv) Bathing. (v) Dressing. (vi) Continence.	§1915(i) Home and Community Based Services (HCBS) State Plan Services NEEDS-BASED EVALUATION/ REEVALUATION, 5. Needs-based HCBS Eligibility Criteria.pg 7 §1915(i) Home and Community Based Services (HCBS) State Plan Services PERSON-CENTERED PLANNING & SERVICE DELIVERY, 1. The State assures that there is an independent assessment of individuals determined to be eligible for HCBS. The assessment is based on: pg. 22 Final Rule CMS 2249-F & CMS 2296-F page 50A recipient must need assistance or prompting in at least two Activities of Daily Living (bathing, dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors: 1.At risk of social isolation due to lack of family or social supports. 2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse; Or 3. A history of aggressive behavior if not supervised or if medication is not administered by a registered nurse.	ADHC- In order to be eligible, a recipient must need assistance or prompting in at least two Activities of Daily Living (ADL) which includes bathing, dressing, grooming, toileting, transfer, mobility, eating and must also have one of the following risk factors: 1. At risk of social isolation due to lack of family or social supports; 2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse (RN); or 3. A history of aggressive behavior if not supervised or if medication is not administered by an RN. HBHS- Day Treatment Program-Day habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI). Residential Habilitation Program-Residential Habilitation-targeted to individuals with TBI or ABI.	MSM Chapter 1800, Section 1803.1 MSM Chapter 1800, Section 1803.1A(2)(b), MSM Chapter 1800, Section 1803.1A(2)(c)
Meets needs-based criteria completed annually or more frequently, as needed.	The State assures that needs-based re-evaluations are conducted at least annually.	§1915(i) Home and Community Based Services (HCBS) State Plan Service's NEEDS-BASED EVALUATION/REEVALUATION, 4. Reevaluation Schedule	Prior to the 12-month authorization period ending, the Health Care Coordinator will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment to determine whether the recipient continues to meet needs-based criteria. The POC will be updated during the re-evaluation assessment and the recipient/designated representative will receive a copy of the POC which must be signed.	MSM Chapter 1800, Section 1803.6C (1)(a)
Proof of diagnosis of TBI/ABI			Day habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI). Residential Habilitation-targeted to individuals with TBI or ABI.	MSM Chapter 1800, Section 1803.1A(2)(c)(3)(e)

Recipient contacted within 7 working days of referral date.			ADHC/HBHS-The DHCFP Health Care Coordinator will contact the applicant/representative within seven working days of the referral date to schedule a time to conduct an assessment.	MSM 1800, Section 1803.6(a)(2)
Recipient contacted within 30 days of PA ending to initiate a face-to-face re-evaluation.			ADHC/HBHS-Prior to the 12-month authorization period ending, the Health Care Coordinator will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment to determine whether the recipient continues to meet needs-based criteria. The POC will be updated during the re-evaluation assessment and the recipient/designated representative will receive a copy of the POC which must be signed.	MSM 1800, Section 1803.6(c)(1)(a)
Provider Service Plan (SP)				
SP completed within 30 days of PA			ADHC/HBHS-A service plan must be completed within 30 days of the recipient beginning services.	MSM Chapter 1800, Section 1803.1B(7)
SP is updated annually or more frequently as needed.	State Plan-Is reviewed at least annually and as needed when there is significant change in the individual's circumstances. 1915(i) HCBS Written Person-Centered Service Plan Documentation Must be reviewed and revised upon reassessment of functional need as required every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.	§1915(i) Home and Community Based Services (HCBS) State Plan Services Person-Centered Planning & Service Delivery, (4) Final Rule CMS 2249-F & CMS 2296-F pg. 40	ADHC facility. The physician must re-evaluate the recipient annually within the same month, or when a significant change occurs. HBHS- The Service Plan must be re-evaluated annually or when a significant change occurs.	MSM Chapter 1800, Section 1803.1B(5)(3)
ADHC/HBHS-Frequency/ Duration/Scope of each service is identified on SP.	Services include the amount, duration, scope, provider, and location.	Final Rule CMS 2249-F & CMS 2296-F pg. 55	ADHC/HBHS-The service plan is developed by the provider using the 1915(i) HCBS Plan of Care (POC) and includes the identified needs from the POC. The service plan must include the description of services and amount of time (hourly, daily, weekly).	MSM Chapter 1800, Section 1803.1B(7)

SP signed by all individuals & providers responsible.	The QIO-like agency employs licensed registered nurses and licensed social workers to evaluate/re-evaluate for eligibility. 2. All the individuals performing evaluations/reevaluations will have professional credentials and experience in evaluating an individual's needs for medical and social supports. HCBS written person-centered service plan documentation: -plain language and understandable to the individual -Who is responsible for monitoring the plan -Informed consent of the individual in writing -Signatures of all individuals and providers responsible	§1915(I) Home and Community Based Services (HCBS) State Plan Services Needs-Based Evaluation/Reevaluation 2. Qualifications of Individuals Performing Evaluation/Reevaluation. Final Rule CMS 2249-F & CMS 2296-F pg. 38	ADHC/HBHS- The provider may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements. If the provider uses a signature page, it must be included in the recipient file.	MSM Chapter 1800, Section 1803.1B(7)
SP signed by recipient/designated representative			ADHC/HBHS-The recipient must provide a signature on the Service Plan. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign for the recipient.	MSM Chapter 1800, Section 1803.1B(7)
SP was completed using Person Centered Planning.	The State assures that, based on the independent assessment, the individualized plan of care: • Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process CMS Person-Centered Service Plans ~ The person-centered service plan must be developed through a person-centered planning process.	STATE PLAN: §1915(i) Home and Community Based Services (HCBS) State Plan Services Person-Centered Planning & Service Delivery, (2) Final Rule CMS 2249-F & CMS 2296-F pg. 29	ADHC/HBHS-For applicants determined eligible for 1915(i) services, a person-centered POC will be developed that includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. The recipient, family, support systems and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible.	MSM Chapter 1800, Section 1803.6B
SP documents choice of services and providers.	The information reviewed with the recipient/personal representative include: process for development of the POC, services to be provided, and choice of service provider. Home and Community Based Setting Requirements ~ Facilitates individual choice regarding services and supports and who provides them.	STATE PLAN: §1915(i) Home and Community Based Services (HCBS) State Plan Services(7) Person-Centered Planning & Service Delivery Final Rule CMS 2249-F & CMS 2296-F pg. 12	ADHC/HBHS- Facilitation of individual's choice regarding services and supports and who provides the services is given during the initial assessment. The recipient must sign the Statement of Understanding (SOU) acknowledging they had the right to choose the services and providers.	MSM Chapter 1800, Section 1803.6B(5)

SP was completed using Person Centered Planning.	The State assures that, based on the independent assessment, the individualized plan of care: • Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process CMS Person-Centered Service Plans ~ The person-centered service plan must be developed through a person-centered planning process.	STATE PLAN: §1915(i) Home and Community Based Services (HCBS) State Plan Services Person-Centered Planning & Service Delivery, (2) Final Rule CMS 2249-F & CMS 2296-F pg. 29	ADHC/HBHS-For applicants determined eligible for 1915(i) services, a person-centered POC will be developed that includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. The recipient, family, support systems and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible.	MSM Chapter 1800, Section 1803.6B
SP documents choice of services and providers.	The information reviewed with the recipient/personal representative include: process for development of the POC, services to be provided, and choice of service provider. Home and Community Based Setting Requirements ~ Facilitates individual choice regarding services and supports and who provides them.	STATE PLAN: §1915(i) Home and Community Based Services (HCBS) State Plan Services (7) Person-Centered Planning & Service Delivery Final Rule CMS 2249-F & CMS 2296-F pg. 12	ADHC/HBHS- Facilitation of individual's choice regarding services and supports and who provides the services is given during the initial assessment. The recipient must sign the Statement of Understanding (SOU) acknowledging they had the right to choose the services and providers.	MSM Chapter 1800, Section 1803.6B(5)
DHCFP Plan of Care (POC)				
POC addresses needs identified on the SP.	Service plans address assessed needs of 1915(i) participants. Current service plans exist in the file. Service plan addresses all the assessed needs.	State Plan: Person-Centered Planning & Service Delivery (1)(a) §1915(i) Home and Community Based Services (HCBS) State Plan Services, Quality Management Strategy, Evidence (1&2)	ADHC/HBHS- The service plan is developed by the provider using the 1915(i) HCBS Plan of Care (POC) and includes the identified needs from the POC. The service plan must include the description of services and amount of time (hourly, daily, weekly).	MSM Chapter 1800, Section 1803.1B(7)
POC address assessed needs identified on CSHA.	A POC form must be developed for all potential recipients. The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided.	§1915(i) Home and Community Based Services (HCBS) State Plan Services, Person-Centered Planning & Service Delivery, (6)	ADHC/HBHS- The POC is person-centered, based on personalized goals, needs, preferences and developed with participation from the recipient, the family, the designated representative and anyone else the recipient chooses. The Health Care Coordinator documents this information in the CSHA narrative.	MSM Chapter 1800, Section 1803.6B(2)
POC identifies the objectives/goals of the plan for care.	A POC form must be developed for all potential recipients. The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided.	§1915(i) Home and Community Based Services (HCBS) State Plan Services, Person-Centered Planning & Service Delivery, (6)	ADHC- The POC…includes objectives and directives for all medication administration and management, social and recreational activities, case management and nutritional needs.	MSM Chapter 1800, Section 1803.1B(2)(a)

POC is updated annually or more frequently as needed.	HCBS Written Person-Centered Service Plan Documentation~ must be reviewed and revised upon reassessment of functional need as required every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.	Final Rule CMS 2249-F & CMS 2296-F pg. 40	ADHC/HBHS- Prior to the 12-month authorization period ending, the Health Care Coordinator will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment to determine whether the recipient continues to meet needs-based criteria.	MSM Chapter 1800, Section 1803.1C(a)(1)
Frequency/Duration/Scope/Amount of each service is identified.	Services include the amount, duration, scope, provider, and location.	Final Rule CMS 2249-F & CMS 2296-F pg. 55	ADHC/HBHS-The POC identifies the services required, including type, scope, amount, duration and frequency of services.	MSM Chapter 1800, Section 1803.6B(6)
POC signed by recipient/LRI with legal documents.	1915(i) HCBS Person-Centered Service Plans pg. 34: -Includes risk factors and plans to minimize them - Signed by all individuals and providers responsible for its implementation Written Person-Centered Service Plan documentation pg. 38: - Plain language and understandable to the individual - who is responsible for monitoring the plan - informed consent of the individual in writing - signatures of all individuals and providers responsible.	Final Rule CMS 2249-F & CMS 2296-F pg. 34 & 38	ADHC/HBHS- A recipient will receive a copy of the initial POC which must be signed within 60 calendar days of the date of the Statement of Understanding (SOU). If the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. The Health Care Coordinator document the recipient's verbal approval in the CSHA narrative and obtain the signature and date on the finalized POC.	MSM Chapter 1800, Section 1803.6B(7)
POC signed by DHCFP HCC and Provider			ADHC/HBHS- provider must sign and date a copy of all new, or a reported change, POCs within 60 calendar days	MSM Chapter 1800, Section 1803.6B(7)
POC was completed using Person Centered Planning.	HCBS written person-centered service plan documentation: -plain language and understandable to the individual -who is responsible for monitoring the plan -informed consent of the individual in writing -signatures of all individuals and providers responsible	Final Rule CMS 2249-F & CMS 2296-F pg. 38	ADHC/HBHS- For applicants determined eligible for 1915(i) services, a person-centered POC will be developed that includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. The recipient, family, support systems and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible.	MSM Chapter 1800, Section 1803.6B

POC updated when changes to the recipient occur during authorization period.	Plan of Care a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers. The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.	State Plan: Quality Improvement Strategy (1) State Plan: Person-Centered Planning & Service Delivery (3)	ADHC/HBHS- If a recipient has a change in condition during the authorization period, the Health Care Coordinator will conduct a visit to update the POC with the recipient/designated representative. A copy of the signed, updated POC will be provided to the recipient and service provider.	MSM Chapter 1800, Section 1803.6C(2)
Recipient signature indicating received information & contact list for reporting critical incidences at initial and annual assessments	During initial and annual assessment, potential recipient/recipient will be educated and sign the acknowledgement form indicating they were given information on how report and provided a list of contacts for reporting critical incidence.	STATE PLAN: §1915(i) Home and Community Based Services (HCBS) State Plan Services Person-Quality Improvement Strategy(7)		
SOU Signed by recipient acknowledging they had the right to choose the services and providers at initial assessment/annually	HCBS Setting Requirements ~ Facilitates individual choice regarding services and supports and who provides them	STATE PLAN: §1915(i) Home and Community Based Services (HCBS) State Plan Services Person-Centered Planning & Service Delivery Final Rule CMS 2249-F & CMS 2296-F pg. 12	ADHC/HBHS- Facilitation of individual's choice regarding services and supports and who provides the services is given during the initial assessment. The recipient must sign the Statement of Understanding (SOU) acknowledging they had the right to choose the services and providers.	MSM 1800, Section 1803.6(B)(5)

Financial Review Requirements				
Assurance	**NAC/State Plan/CMS**	**State Plan /CMS**	**MSM Requirement**	**MSM Chapter**
Eligibility				
Enrollee eligible on the date of service.	The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). SMA Health Care Coordinator (HCC) conducts a face-to-face visit with a potential recipient to determine whether the needs-based criteria will be met. The face-to-face assessment may be performed by telemedicine, when the following conditions are met: -The agent performing the assessment is independent and qualified and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology; -The individual receives appropriate support during the assessment, including the use of any necessary on-site support staff; and -The individual provides informed consent for this type of assessment. The Health Care Coordinator uses the Comprehensive Social Health Assessment (CSHA) which is a tool to assess medical, social, and psychological condition of a potential recipient.	§1915(i) Home and Community Based Services (HCBS) State Plan Services Financial Eligibility §1915(i) Home and Community Based Services (HCBS) State Plan Services Needs-Based Evaluation/Reevaluation 3. Process for Performing Evaluation/Reevaluation.	All providers must verify each month continued Medicaid eligibility for each recipient. This can be accomplished by utilizing the electronic verification system (EVS) or contacting the eligibility staff at the welfare office hotline. Verification of Medicaid eligibility is the sole responsibility of the provider. PROGRAM ELIGIBILITY a. An individual must meet and maintain Medicaid eligibility. b. An individual must be 18 years of age or older. c. An individual must meet the needs-based eligibility requirements. d. The individual must reside in the community. NEEDS-BASED ELIGIBILITY CRITERIA The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual's support needs and risk factors. In order to be eligible, a recipient must need assistance or prompting in at least two Activities of Daily Living (ADL) which includes bathing, dressing, grooming, toileting, transfer, mobility, eating and must also have one of the following risk factors: 1. At risk of social isolation due to lack of family or social supports; 2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse (RN); or 3. A history of aggressive behavior if not supervised or if medication is not administered by an RN. The DHCFP Health Care Coordinator (HCC) conducts the needs-based eligibility determinations.	MSM Chapter 1800, Section 1803.1B(2) MSM Chapter 1800, Section 1803.1A(1)(a)(b)(c) (d) MSM Chapter 1800, Section 1803.1
Are there any conflicting services provided during the review month/service dates (*Institutional care*)?	Non-duplication of services. State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.	§1915(i) Home and Community Based Services (HCBS) State Plan Services	Services rendered to a recipient who is no longer in the community setting but is institutionalized (hospital, nursing facility, correction or Intermediate Care Facility (ICF) for intellectual or developmental disabilities). For Adult Day Health Care (ADHC), a recipient who resides in a residential setting such as group home, assisted living or other type of residential facility where a per diem rate is paid for 24-hour care is not eligible for ADHC services. Day Habilitation services are regularly scheduled activities in a non-residential setting, separate from the recipient's private residence or other residential living arrangement. Services include assistance with the acquisition, retention or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing ADL and	MSM Chapter 1800, Section 1803.1A(3)(c) MSM Chapter 1800, Section 1803.1A(3)(d) MSM Chapter 1800, Section 1803.4

			community living.	
Prior Authorization				
Is service prior authorized?	Prior authorization must be obtained through the QIO-like vendor using universal needs assessment tool. This same process is used to both evaluate and reevaluate whether an individual is eligible for the 1915(i) services	§1915(i) Home and Community Based Services (HCBS) State Plan Services Needs-Based Evaluation/Reevaluation 3. Process for Performing Evaluation/Reevaluation	ADHC-Services must be prior authorized. If a PA is required, it is the The DHCFP Health Care Coordinators are responsible for prior authorizing 1915(i) services. If a PA is required, it is the responsibility of the provider to request before providing services..... Requirement for all services to be prior authorized to be eligible for reimbursement	MSM Chapter 1800, Section 1803.6B(9) MSM Chapter 100, Section 103.2(d) MSM Chapter 3300, Section 3303.3A(2)(k)(1)(1)
Claims				
Procedure code correct	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual.	§1915(i) Home and Community Based Services (HCBS) State Plan Services	Claim billed with incorrect procedure code. Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information.	MSM Chapter 3300, Section 3303.2A(4)(1)(b) MSM Chapter 100, Section 105.1F
Service units billed fall within the POC units allowed.			The POC identifies the services required, including type, scope, amount, duration and frequency of services. The service providers are contacted by the Health Care Coordinator to establish availability and are given a copy of the recipient's POC prior to the initiation of services. Claims submitted are only for services rendered. The number of units billed was incorrect.	MSM Chapter 1800, Section 1803.6B(6) MSM Chapter 100, Section 103(B)(4) MSM Chapter 3300, Section 3303.2A(4)(1)(d)
Is the amount billed correct?			Incorrect rate was used to pay the claim.	MSM Chapter 3300, Section 3303.2A(4)(2)(d)
Daily Records				
Services provided on nursing logs match the POC	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	1915(i) Home and Community Based Services (HCBS) State Plan Services, Section Quality Management Strategy	Providers are required to keep any records necessary to disclose the extent of services the provider furnishes to recipients and to provide these records, upon request, to the Medicaid agency, the Secretary of Health and Human Services (HHS), or the state Medical Fraud Control Unit (MFCU). The POC identifies the services required, including type, scope, amount, duration and frequency of services. The service providers are contacted by the Health Care Coordinator to establish availability and are given a copy of the recipient's POC prior to the initiation of services.	MSM Chapter 100, Section 105.1L MSM Chapter 1803.6B(6)

Frequency of Services on nursing logs match the POC.			The POC identifies the services required, including type, scope, amount, duration and frequency of services. The service providers are contacted by the Health Care Coordinator to establish availability and are given a copy of the recipient's POC prior to the initiation of services.	MSM Chapter 1800, Section 1803.6B(6)
Service units/days provided match the units/days billed and for which payment was received.			No documentation or insufficient documentation provided within specified timeframes to support the service billed and paid by the DHCFP. At a minimum, the following items will be considered PERM Review Errors resulting from medical reviews: d. The number of units billed was incorrect.	MSM Chapter 3300, Section 3303.2A(4)(a)(1)(a) MSM Chapter 3300, Section 3303.2A(4)(a)(1)(d)
Daily attendance & nursing log signed by recipient.			The center must have documentation of daily attendance and notes that indicate the health component of this service, which is maintained in the recipient's file. This documentation is verification of service provision and may be used to review claims paid. The delivery of specific services required by the POC and outlined in the Service Plan must be documented in the daily records. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting the recipient's care. The recipient and a center staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient. The center may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements. MSM Addendum ~ Attendance Record The attendance record is documentation by a facility, indicating the time the recipient arrived at the facility and the time the recipient left the facility. The recipient and a facility staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. An authorized representative may sign on behalf of the recipient.	MSM Chapter 1800, Section 1803.1B(2)(d) MSM Addendum Section A page 12
Daily attendance & nursing/daily log provider staff			The center must have documentation of daily attendance and notes that indicate the health component of this service, which is maintained in the recipient's file. This documentation is verification of service provision and may be used to review claims paid. The delivery of specific services required by the POC and outlined in the Service Plan must be documented in the daily records. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting the recipient's care. The recipient and a center staff member must sign each record. If the	MSM Chapter 1800, Section 1803.1B(2)(d) MSM Addendum Section A page 12

			recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient. The center may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements. MSM Addendum ~ Attendance Record The attendance record is documentation by a facility, indicating the time the recipient arrived at the facility and the time the recipient left the facility. The recipient and a facility staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. An authorized representative may sign on behalf of the recipient.	
If applicable, documented by CM recipient is unable to sign due to cognitive &/or physical limitations (cannot be signed by provider).			The recipient and a center staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient. MSM Addendum ~ ATTENDANCE RECORD The attendance record is documentation by a facility, indicating the time the recipient arrived at the facility and the time the recipient left the facility. The recipient and a facility staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. An authorized representative may sign on behalf of the recipient.	MSM Chapter 1800, Section 1803.2B(2)(d) MSM Addendum Section A page 12
If applicable, provider submitted signature page			The center may create a signature page which can encompass a recipient signature for the Service Plan and any other signature requirements. MSM Addendum ~ ATTENDANCE RECORD The attendance record is documentation by a facility, indicating the time the recipient arrived at the facility and the time the recipient left the facility. The recipient and a facility staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. An authorized representative may sign on behalf of the recipient.	MSM Chapter 1800, Section 1803.3B (2)(d) MSM Addendum Section A page 12
Payments				
Payment to provider correct based on claim submitted.	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual.	§1915(i) Home and Community Based Services (HCBS) State Plan Services	Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information. Incorrect rate was used to pay the claim.	MSM Chapter 100, Section 105.1F MSM Chapter 3300, Section 3300.2A(4)(a)(2)(d)

Services paid according to the Medicaid allowable rate.	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual	§1915(i) Home and Community Based Services (HCBS) State Plan Services	Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the HIPAA of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information. Incorrect rate was used to pay the claim.	MSM Chapter 100, Section 105.1F MSM Chapter 3300, Section 3300.2A(4)(a)(2)(d)
Overpayment to provider.			An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with: The Medicaid or Nevada Check Up policy governing the service provided; fiscal agent billing manuals; contractual requirements; standard record keeping requirements of the provider discipline; and federal law or state statutes. An improper payment can be an overpayment or an underpayment. Improper payments...	MSM Chapter 3300, Section 3302.4
Referral made to Surveillance and Utilization Review (SUR) unit.	…If necessary, the results of the financial review are provided to the DHCFP Surveillance and Utilization Review Unit.	Appendix I: Financial Integrity, Section I- 1: Financial Integrity and Accountability, (b)	The DHCFP may initiate a corrective action plan against a provider as the result of an investigation, audit and/or review. Investigations, audits or reviews may be conducted by one or more of the following (not all inclusive): c. Nevada Medicaid Surveillance Utilization and Review (SUR) staff…	MSM Chapter 100, Section 106.5(c)
Provider				
Provider eligible for payment (active) at time of service provision.	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual.	1915(i) State Plan §1915(i) Home and Community Based Services (HCBS) State Plan Services	In addition to this chapter, providers must also comply with rules and regulations for providers as set forth in the MSM Chapter 100. Each 1915(i) service outlines specific provider qualifications which must be adhered to in order to render that 1915(i) service. Each provider of ADHC services must obtain and maintain licensure as required in the 1915(i) State Plan and NAC Chapter 449. Furthermore, providers must adhere to all requirements of NAC 449 as applicable to licensure. All individuals/entities providing services to Medicaid recipients under the FFS or Medicaid Managed Care program must be enrolled as a Medicaid provider in order to receive payment for services rendered.	MSM Chapter 1800, Section 1803.1B(1) MSM Chapter 100, Section 102

Acronyms & Definitions 1915(i) ADHC & HBHS

ABI- (ACQUIRED BRAIN INJURY)

Refers to impaired brain functioning due to a medically verifiable incident including, but not limited to: 1. a cerebral vascular accident; 2. a ruptured aneurysm; 3. anoxia; or 4. hypoxia and brain tumors. Not all acquired brain injuries require or meet criteria for comprehensive rehabilitation services**.**

ADHC- (ADULT DAY HEALTH CARE)

An organized program of services during the day in a group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being.

ADL- (ACTIVITIES OF DAILY LIVING)

Self-care activities routinely performed daily, such as bathing, dressing, grooming, toileting, transferring, mobility, continence and eating.

ADSD- (AGING AND DISABILITY SERVICES DIVISION)

A state agency that is part of Nevada's Department of Health and Human Services (DHHS) and is the operating agency of the Home and Community Based Services (HCBS) Waivers for the Frail Elderly, Physically Disabled, and Individuals with Intellectual Disabilities.

ALiS- (ONLINE PROVIDER REVIEW SYSTEM)

The Online Provider Review System (ALiS) allows users to schedule, complete, and provide results of an annual inspection for Nevada Medicaid's Home and Community Based Services (HCBS) providers.

ASA- (ANNUAL SOCIAL ASSESSMENT)

An assessment that is annually reviewed that addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.

CFR- (CODE OF FEDERAL REGULATIONS)

The CFR is a codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal government. The Code is divided into 50 titles which represent broad areas subject to federal regulation.

CM- (CASE MANAGEMENT)

Case management is a process by which an individual's needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Case management may be targeted to certain populations in certain areas of the state under the authority of Section 1905(a)(19) of the Social Security Act

CM- (CASE MANAGER)

A case manager is a specialized social worker and healthcare professional who oversees and coordinates the continued care of clinical patients. They often work with patients with long-term or chronic illnesses, ensuring that these patients receive effective care.

CMS- (CENTERS FOR MEDICARE AND MEDICAID SERVICES)

The Federal government entity that monitors state programs to assure minimum levels of public health service are provided, as mandated in the 42 CFR.

CSHA- (COMPREHENSIVE SOCIAL HEALTH ASSESSMENT)

An assessment that addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.

CRS- (CONTINUED STAY CRITERIA)

Continued stay criteria means specific criteria to be considered in determining appropriate client/patient placement for continued stay at a level of care or referral to a more appropriate level of care.

DTP- (DAY TREATMENT PROGRAM)

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least two days a week by a multidisciplinary staff under the clinical supervision of a mental health professional.

DHCFP- (DIVISION OF HEALTH CARE FINANCING AND POLICY)

A state agency that is part of Nevada's Department of Health and Human Services (DHHS) that works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources.

DME- (DURABLE MEDICAL EQUIPMENT)

Medically necessary durable medical equipment that a doctor prescribes for use in the home.

FA-17- (1915(i) HCBS UNIVERSAL NEEDS ASSESSMENT)

The 1915(i) HCBS Universal Needs Assessment Tool must be used to evaluate and reevaluate whether an individual is eligible for the Nevada 1915(i) HCBS state plan services.

FE- (HCBS WAIVER FOR THE FRAIL ELDERLY)

A 1915(c) Waiver Program (formerly Community Home Base Initiative Program) that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for the frail elderly who would otherwise need institutional nursing facility services.

FPL- (FEDERAL POVERTY LEVEL)

HA- (HEALTH ASSESSMENT)

Health assessment is the evaluation of the health status by performing a physical exam after taking a health history.

HBHS- (HOME BASE HABILITATION SERVICES)

Home base habilitation services (HBHS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

HCBS- (HOME AND COMMUNITY-BASED SERVICES)

Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

HCC- (HEALTH CARE COORDINATOR)

Health care coordinators, also called medical or health service managers, oversee the organizational aspects of patient care in healthcare organizations.

HCQC- (HEALTH CARE QUALITY COMPLIANCE)

The Bureau of Health Care Quality and Compliance (HCQC) licenses the following health facility types in Nevada.

HIPAA- (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

HHS- (HEALTH AND HUMAN SERVICES)

The United States Department of Health and Human Services is a cabinet-level executive branch department of the U.S. federal government created to protect the health of all Americans and providing essential human services.

IA- (INITIAL ASSESSMENT)

This assessment is conducted as an administrative function of the waiver program and evaluates service needs based on functional deficits, support systems and imminent risk of institutionalization.

IADL- (INSTRUMENTAL ACTIVITIES OF DAILY LIVING)

Activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication, and

money management.

ICD- (INTERNATIONAL CLASSIFICATION DISEASE)

ICD serves a broad range of uses globally and provides critical knowledge on the extent, causes and consequences of human disease and death worldwide via data that is reported and coded with the ICD.

ID- (INTELLECTUAL DISABILITY)

A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

LRI- (LEGALLY RESPONSIBLE INDIVIDUAL)

Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents, and adoptive parents.

LTSS- (LONG TERM SERVICES AND SUPPORTS)

A unit within the Division of Health Care Financing and Policy that provides services specifically to Medicaid eligible recipients. This includes services for a diverse group of Nevadans including the elderly and people living with disabilities and special health care needs. LTSS provides both institutional and home and community-based care.

MD- (MEDICAL DOCTOR)

A licensed medical practitioner.

MFCU- (MEDICAID FRAUD CONTROL UNIT)

Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as abuse or neglect of residents in health care facilities and board and care facilities and of Medicaid beneficiaries in noninstitutional or other settings.

MMIS- (MEDICAID MANAGEMENT INFORMATION SYSTEM)

A computer system designed to help managers plan and direct business and organizational operations.

MSM- (MEDICAID SERVICES MANUAL)

The policies that govern Medicaid services.

NAC- (NEVADA ADMINISTRATIVE CODE)

The Nevada Administrative Code (NAC) is the codified, administrative regulations of the Executive Branch. The Nevada Register is a compilation of proposed, adopted, emergency and temporary administrative regulations, notices of intent and informational statements.

NF- (NURSING FACILITY)

NF is a general Nursing Facility, free-standing or hospital-based, which is licensed and certified by the Division of Public and Behavioral Health, Health Care Quality and Compliance, and provides both skilled and intermediate nursing services.

NMO- (NEVADA MEDICAID OFFICE)

The Nevada Medicaid Office is responsible for policy, planning and administration of the Nevada Medicaid program; also known as the Division of Health Care Financing and Policy.

PA- (PRIOR AUTHORIZATION)

Prior Authorization Request Nevada Medicaid and Nevada Check Up Adult Day Health Care (ADHC) request prior authorization for ADHC services through the Nevada Medicaid program.

PCA- (PERSONAL CARE ASSISTANT)

Personal care assistants, also known as caregivers, home health or personal care aides, give assistance to people who are sick, injured, mentally or physically disabled, or the elderly and fragile.

PCP- (PERSON CENTERED PLANNING)

An assessment and service planning process are directed and led by the individual, with assistance as needed or desired from representatives or other persons of the individuals choosing. The process is designed to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the community.

PCS- (PERSONAL CARE SERVICES)

Hands-on assistance with activities of daily living (ADLs) (such as eating, bathing, dressing, and bladder and bowel requirements) or instrumental activities of daily living (IADLs) (such as taking medications and shopping for groceries).

PD- (HCBS WAIVER SERVING PEOPLE WITH PHYSICAL DISABILITIES)

A 1915(c) Waiver Program that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for persons with physical disabilities who would otherwise need institutional nursing facility services.

PERS- (PERSONAL EMERGENCY RESPONSE SYSTEM)

An electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a landline and programmed to signal a response center once the "help" button is activated.

PES- (PARTICIPANT EXPERIENCE SURVEY)

The Participant Experience Survey (PES) is an interview tool developed by MEDSTAT under a contract from the CMS. The survey captures data that can be used to calculate indicators for monitoring quality within the HCBS programs.

POC- (PLAN OF CORRECTION)

A provider's plan for how and when it will correct Federal deficiencies and/or state violations.

P&P- (POLICY & PROCEDURE)

A transmittal issued on policies adopted by the DHCFP to provide clarification and guidance within the boundaries of that policy.

QA- (QUALITY ASSURANCE)

A structured, internal monitoring and evaluation process designed to improve quality of care. QA involves the identification of quality of care criteria, which establishes the indicators for program measurements and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

QI- (QUALITY IMPROVEMENT)

A critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

QIO- (QUALITY IMPROVEMENT ORGANIZATIONS)

A Quality Improvement Organization (QIO) is a group of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare.

QIS- (QUALITY IMPROVEMENT STRATEGY)

RN- (REGISTERED NURSE)

RHP- (RESIDENTIAL HABILITATION PROGRAM)

SA- (SOCIAL ASSESSMENT)

An assessment that is annually reviewed that addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.

SAMS- (SOCIAL ASSISTANCE MANAGEMENT SOFTWARE)

Social Assistance Management Software or SAMS® manages consumer (recipient) and service data for social assistance organizations.

SC- (SERVICE COORDINATOR)

Responsible for monitoring and documenting the provision of waiver services, as well as recipient health and welfare. The Developmental Specialist or Psychiatric Caseworker qualified by educational background or training to assist, advise, direct, and oversee services to eligible individuals.

SMA- (STATE MEDICAID AGENCY)

Medicaid agency or agency means the single State agency administering or supervising the administration of a State Medicaid plan.

SOC- (STATEMENT OF CHOICE)

A form given to all applicants describing the services offered under the waiver during the intake process. The assigned Service Coordinator informs the applicant of their choice between waiver services and placement in an ICF/ID, in addition to their choice of qualified providers.

SOR- (SERIOUS OCCURRENCE REPORT)

A report of any actual or alleged event or situation involving either the provider/employee or recipient that relates a substantial or serious harm to the safety or wellbeing of the provider/employee or recipient. Serious occurrences may include, but are not limited to the following: suspected physical or verbal abuse, unplanned hospitalization, neglect of the recipient, exploitation, sexual harassment or sexual abuse, injuries requiring medical intervention, an unsafe working environment, any event which is reported to Child or Elder Protective Services or law enforcement agencies, death of the recipient during the provision of waiver services (PCS), or loss of contact with the recipient for three consecutive scheduled days.

SOU- (STATEMENT OF UNDERSTANDING)

A form given to all applicants describing the services offered under the waiver during the intake process. The assigned Service Coordinator informs the applicant of their choice between waiver services and placement in an ICF/ID, in addition to their choice of qualified providers.

SP- (SERVICE PLAN)

Health care service plan means a plan that undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

SPA- (STATE PLAN AMENDMENT)

A Medicaid and 1915(i) state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and 1915(i) programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities.

SUR- (SURVEILLANCE AND UTILIZATION REVIEW)

A statewide program that safeguards against unnecessary or inappropriate use of services by preventing excess payments in the Nevada Medicaid and Nevada Check Up programs. The SUR unit analyzes claims data to identify potential fraud, waste, overutilization and abuse; collects provider overpayments and refers appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution.

TBI- (TRAUMATIC BRAIN INJURY)

A traumatic brain injury is a medically verifiable incident of the brain not of a degenerative or cognitive nature, but caused by an external force, that may produce a diminished or altered state of consciousness, which results in an impairment of cognitive abilities or functioning. It can also result in a disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and can cause partial or total functional disability or psychosocial maladjustment.

TCM- (TARGETED CASE MANAGEMENT)

Targeted case management is case management services provided only to specific classes of individuals, or to individuals who reside in specific areas of the state (or both). Presently, Nevada State Medicaid has “targeted” case management services to specific classes of individuals.

UNA- (UNIVERSAL NEEDS ASSESSMENT)

Universal Needs Assessment is a tool for 1915(i) Services used to determine whether a recipient is eligible for 1915(i) services through Nevada Medicaid. Assessment must be performed face-to-face by the recipient’s physician who is an independent third party.